the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE

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The Cover

● *Katzenjammer* is a graphic expression for the discomfort after immoderate consumption of alcohol. "To jerk the cat" was once colloquial usage for "to vomit," especially after drinking. An article on the "hangover" begins on page 73.

● The cover representation of a sick cat is by Joseph F. Schwarting.

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CONTENTS

The physician whose patient is tattooed may have no occasion to be concerned with the motivation for it. If the real or ostensible reasons are discussed at all—and probably they will not be—the most likely explanation will be of an experience while in military or naval service, usually affected by inebriety. Seemingly the decision to be tattooed is ordinarily undertaken in a group and has the connotation of a dare, of being a part of that group, a matter of camaraderie and deviltry or of lightheartedness under duress. The physician may well wonder, at such a time, if this sign of group membership or belongingness does not signify exactly the reverse. The individual has, after all, decided to ignore the social climate and, often, the mores of his community. The traditional reasons for this "egocentric perversion" have changed, and, whether it is a masochistic mechanism, a superstitious gesture, or an effort at identity, some degree of conflict is apparent. An expression of the personality structure is thus evident on the skin surface.

The tattoo has had a multitude of meanings—cosmetic, social, religious, ethnological, remedial, and fraternal. The term is much younger than the fact, of course, and the anthropological significance of the tattoo has become delimited and greatly altered. Uses in identification and camouflage have no bearing upon the psychiatric implications of tattoo in this particular time and culture.

Although the exact incidence is and will remain unknown, the practice is by no means unusual. For instance, daily, in 1943, an estimated three to five hundred men in Honolulu were being tattooed. Despite historic precedent for the tattoo as decoration, women are much less interested than men or, at least, less willing to mutilate the skin. Of 1175 female criminals reported by Lombroso and Ferraro, thirteen were tattooed. Beerman and Lane cited a necropsy series from Cook County Hospital, as reported by Rukstinat. Among white patients, 8.79 per cent of the men were tattooed but only 0.71 per cent of the women.

Bromberg divided the personalities who elect to decorate the skin in this manner into collectors and imitators. Both groups have in common the ability, on impulse, to abrogate two natural reactions. One is the willingness to defy society, as, currently, such coloration is unfashionable and

THE TATTOO

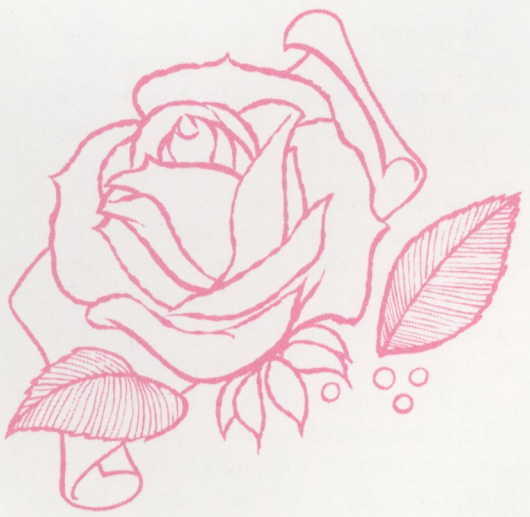
"... a spontaneous projective test."

socially unacceptable. The other is a comparable overcoming of the natural resistance to injury of the skin. Both denials have a relation to reason. For instance, social rebels have often become the social lions of the next generation. In this country and time, however, the implications of tattoo are not of social revolt in the more serious sense of the term. These are rebels of another order. As to modification of the body image, personal adornment is both prevalent and acceptable, although not in this fashion. Even though the major religions—Christianity, Judaism, and Mohammedanism—forbid tattooing, the practice has been maintained.

To Lombroso the tattoo remained the primitive adornment which it originally was, and to him it signified an atavistic regression, but then Lombroso equated most criminality with atavistic phenomena. To later investigators a tattoo seemed an adolescent modification of appearance, comparable to the affecting of conspicuous clothes, like those, some years ago, of the zoot-suiters. Actually, this latter interpretation is not remote from Lombroso's. The skin is, however, peculiarly invested with narcissistic significance. Furthermore, tattooing involves some amount of self-chosen pain, although reports of discomfort vary greatly.

The collectors

Individuals who "collect" tattoos are a large proportion of the total. This group would include the merely exhibitionistic, the public performers, and the well-to-do eccentrics who from reverse snobbery affect this kind of ornamentation. In this number are found the more intricate and imaginative designs, such as the instance of the minister with Biblical texts permanently affixed to his body, or the physician with anatomic pictures and their Latin names. Elaborate drawings are less usual in this culture, and the designs are more commonly pornographic, sentimental, or heroic. The most popular representations are simple and fairly crude stencils, executed mainly in red and blue coloring. Names, initials, and dates are ordinarily employed. The word "Mother" and a dramatic and high-sounding sentiment, such as "Death Before Dishonor" are usual. These are found with roses, anchors, crosses, serpents, the American eagle, mermaids, daggers that drip with blood, ships—



sometimes sinking ones, and gravestones. It has been pointed out that the artistry of tattooing deteriorated as social acceptance declined. Subjects and sites are, in the opinions of some investigators, significant to individual psychopathology. The banal and violent, the mawkish and dramatic both in their collective and individual meanings contribute in this surface exhibition of conflict.

The collector's motivation is perhaps nearer to some of the earlier reasons for tattoo. Besides the exhibitionism there are the factors of superstition, and depiction of a part of one's history or accomplishment. As such a record the tattoo has been, in some civilizations, a serious part of social identification.

The imitators

The tattoo has been equated with the fraternity pin as indication of peer acceptance, but there are also those who do not "belong" in the customary sense. These are the individuals who attempt an identification with the much-travelled, or the accomplished, or the virile. Ferguson-Rayport and associates describe this as a plagiarism of a rite that was at one time serious. The person assumes an unearned emblem.

In this problem of masculine identification the numbers of homosexuals who are tattooed have been commented upon by many investigators. It has been noted that in instances of sexual maladaptation the tattoo has a compensatory function.

In a study of findings at an induction center in 1943 it was reported that tattooed men had a rejection rate 50 per cent greater than those who did not have tattoos, and that of the rejected tattooed men 58 per cent had not been accepted because of neuropsychiatric disorders.

Investigations have been made of the incidence of tattoo in various professions, in criminals, and in armed forces personnel. The high frequency in military service and in penal institutions would seem partially to corroborate some of the theories concerning the imitators or pretenders. It has been pointed out that men in such circumstances are in a predominantly male society and are isolated from accustomed love objects. Both the theories of attempted identification with the group and that of substitute sexuality would seem to have some degree of validity.

In a study of neuropsychiatric patients at Lexington, Kentucky, Ferguson-Rayport and associates reviewed admissions to the Veterans Administration Hospital. In a period of seven months there were 232 first admissions for neuropsychiatric disorders, 37 of whom were tattooed. Of 943 chronic patients at the same hospital 86 were tattooed. These investigators studied the number of tattoos, their location, times and circumstances of reception, and manifest content. In some patients it was possible to utilize Rorschach results to see if correlation were possible.

The authors divided these patients into two groups—schizophrenics and those with personality disorders. There were characteristic differences between the groups in number, sort, site, and content of the tattoos, and demonstrable similarities or consistencies within each group. The schizophrenic patients typically demonstrated their separation from normalcy and reality with tattoos meaningful only to themselves. The element of magic and mystery was pronounced but the significance was individual. The patients with personality disorders showed in their multiplicity of tattoos and in their choices of design both their own internal conflicts and their discord with the standards of society. These scientists stated in conclusion that "Comparison of tattoo constellations and

Rorschach responses suggests that the tattoo may be considered akin to a spontaneous projective test."

Nonpsychiatric patients

Beerman and Lane have stressed the point that many "normal" persons acquire tattoos. In patients who are not ostensibly maladjusted there may yet be some points that the physician will wish to consider in reference to the individual personality. One is the factor of impulsiveness and lability. Another is the indication of immaturity. A third is the evidence of gregariousness or pseudogregariousness, the wish at whatever social cost to be even temporarily a part of a particular group. The possibility of an exhibitionistic tendency is also to be remembered.

The risks of infection, reactions to pigment, and subsequent possible complications to being tattooed are formidable indeed; however, the physician cannot assume that the patient was brave enough to flout all the dangers. It is much more likely that he was unaware of them.

Conclusion

The accumulated scientific literature about tattooing is only a little more than a hundred years old, and the word itself was not used in English until the eighteenth century. The practice, however, has been traced as far back as 4000 B.C. The ritual meanings have long since disappeared and the social values have changed. Medically the most immediate problem is usually that of removal. Nevertheless, the tattoo has psychologic significance, although not necessarily morbid, as it is one depiction of personality structure. The individual bears visible evidence of one kind of behavior pattern.

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The Halfway House

The Halfway House is a residential facility in which psychiatric patients may live temporarily during the transition from the sheltered life of the mental hospital to the family and community. There are now seven Halfway Houses in widely separated locations across the country. Their establishment has been based on two premises: (1) A normal social and work environment can be therapeutic, and (2) Money as a conventional reward for labor in our society is an incentive in the rehabilitation of patients who have been mentally ill. Need for such a bridge between hospital and community has long been recognized by psychiatrists. After lengthy hospitalization, patients become comfortable in the hospital setting, operate on a fairly efficient level, and are able to contribute to the institutional community. Unfortunately, the next step, returning to independence as productive citizens, is not easy.

For patients who have potentialities for healthy living but are not yet ready for the stresses of the outside world, the Halfway House offers an optimum environment for testing adaptability and resolving conflicts which still exist. The direction by a staff of laymen can induce positive attitudes with emphasis on aspects of health rather than on disease.

The need of careful planning

Most of the Halfway Houses have been developed during the last four years, but one, Spring Lake Ranch at Cuttingsville, Vermont, has been in operation for 20 years. Only a few other houses exist at the present time, and two have been closed because of inadequate financing and supervision. The Rutland Corner House in Boston is sponsored by laymen. It opened in 1954, and, that same year, the Modesto State Hospital house was opened in Modesto, California, after two years of planning by the hospital staff. They had the advantage of professional knowledge, but the added duties became too big a burden and the house had to close, although not before it had demonstrated its value.

Community groups working with professional personnel have established installations called The Portals in California in 1955, quarters in 1956 in connection with Agnews State Hospital in California, and The Foster Home Cottage in Brockton, Massachusetts, in 1956. In Vermont, two professional groups worked together and shared responsibility for a comparable program. Their work culminated in the Rehabilitation House for Women in Montpelier in 1956 and a Rehabilitation House for Men in Burlington in 1958.

In one instance, the patients for whom a Halfway House was designed were in charge of a large part of the planning, but this did not prove satisfactory. Some degree of responsibility for planning is good for future occupants of the houses, but they cannot be expected to assume a large part in a complex undertaking.

The financial situation

Financial support is the most important single item to be considered in opening a Halfway House, and the amount of money that will be needed depends on the size of the establishment and the amount of staff. Even when the patients pay board and room after they start to work, all such houses operate at an annual deficit of from $6,000 to $15,000.

Employment for patients is a major part of the rehabilitation. A staff member from the hospital or sponsoring agency helps with finding jobs, personal adjustment problems, and preparation of individual budgets. At the Rehabilitation House in Montpelier, each patient is permitted to keep a portion of her earnings for incidental expenses, savings, and the like. The balance is paid toward

room and board. The women who live there also help with the housework and thus decrease costs.

Choice of location depends on several factors. Proximity to the hospital and nearness to transportation facilities and places of employment are important. The Halfway House should be in a sheltered, homelike environment and must be large enough to accommodate up to 15 patients. An old house in a residential neighborhood seems ideal. If it is not too near the hospital, psychiatrists believe that patients will have a greater feeling of independence. Location of the house may also depend on community relations. Residents of a particular neighborhood sometimes object to such an establishment in the immediate vicinity. In two instances petitions were actually circulated against such houses. In both cases, church and newspaper support for the new occupants helped resolve the objections through an educational campaign.

Criteria for selection of patients

A phenomenon well known in psychiatry is that of a group of patients who have been hospitalized for a long time, but who seem to have come to a standstill in recovery. Continued hospitalization fosters dependency and loss of initiative. These patients may no longer need actual institutional care but realize a need to escape from the stresses of the world. If carefully selected many of these chronically ill patients could do well in healthful environment presided over by lay people instead of doctors and nurses. It remains necessary, however, for such patients to have psychiatric advice and counsel available whenever needed.

The selective procedure of Portals, for example, is based on these considerations: ability to live outside the hospital without supervision, potential for vocational placement, ability to meet financial requirements, and absence of such symptoms as would interfere with group relations.

According to the California Department of Mental Hygiene, an applicant for admission to a Halfway House should be in good remission, have a good potential to sustain himself socially and economically, require a minimum of supervision, and be willing to secure employment and to work toward early discharge. The three broad areas for selection may be broken down into diagnosis, level of social adjustment, and level of working adjustment.

Staff

It is important that the Halfway House be staffed by laymen, and just as important that it be supervised by psychiatrists whose particular duties would include selection of guests and giving psychiatric advice when needed. The living arrangement is planned to offer companionship and the warmth and support of an environment of acceptance after work hours. The residence club type of home, with a house mother and also a "father," best meets the needs, especially of younger patients. All but one of the Houses have had a full-time housekeeper from the time of opening, and the one exception closed. Two of the houses used ex-attendants as house parents with great success. One, Modesto, employed a private citizen, a "mature and patient" woman who owned and ran the house as a rooming house. At the Vermont State Hospital Rehabilitation House, a member of the staff visits the house one evening each week to check on medication, continue group therapy sessions, and help with any current problems. There is also a counselor who works with individual patients to help them find employment, assists with personal adjustment problems, and works on budget plans for the patients. In some instances the hospital prepares future residents for occupancy, and screening of applicants is done by staff members.

Discharged patients

All plans, treatment, and counseling services are ultimately directed toward eventual discharge. The Halfway Houses have an enviable record in this respect. It is expected that after a few months most of the patients will be discharged to a place in the community. They will, however, continue to have follow-up studies and any needed service will be provided for them. Rehabilitation House in Vermont has reported after being in operation for nine months the findings concerning 17 women patients who had lived there. Four were able to leave on outside placement or to return home. Three of them had to go back to the hospital, but one was able to come back to the House within two weeks. At the end of the nine months, ten women were in residence, seven of whom had been employed for over six months and another for one month.

The Manager of Foster Home Cottage, P. A. Peffer, has stated, after a year of operation that "it must be remembered that patients selected to go to the Cottage were chosen because they presented difficult discharge problems, yet had no symptoms to prevent them from living in the community." All 21 patients were schizophrenics who had been hospitalized for years. One became able to be returned to the home of relatives. Eight went to foster homes. Three were returned to the hospital, and all others were functioning adequately at the time of his report. These results were attributed, in part, to the sound follow-up program.

One important consideration for discharge in all of the Halfway Houses seems to be the readiness of the patient to accept a move to the outside world. Another is his degree of financial independence. Vermont, for example, requires that the resident save out of earnings a total of $150.00 before discharge.

Conclusion

There is a need for a bridge between the mental hospital and the community to which patients must return. The possibility always exists that return to the previous environment may cause recurrence. In a Halfway House, the patients can adjust gradually, with the added incentive of remunerative employment which, in itself, acts as a therapeutic measure in rehabilitation.

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Problems of Psychiatric Referral

An interview with Robert T. Morse, M.D., Associate Professor of Psychiatry, Georgetown University Medical School; Training Analyst, Washington Psychoanalytic Institute; Consultant in Psychiatry: Walter Reed Hospital; Regional Office, Veterans Administration, Washington, D.C.; Naval Medical Center, Bethesda, Md.; U.S. Information Agency, Washington, D.C.

What single factor most favorably disposes toward successful psychiatric referral?

A good working relationship between the physicians involved is the most important factor in psychiatric referrals which have a favorable outcome, not only for the physicians but for the patient and his family.

What are the usual reasons for psychiatric referral?

The general reasons for psychiatric referral are the same as those for any other medical referral by a practitioner to a specialist; namely, a need for assistance in a problem of diagnosis, management, or treatment. In psychiatric referral there are significant variations which depend primarily on the orientation or attitude of the referring physician and his professional and personal relationship with the psychiatrist.

What are some of the commonly encountered attitudes of the referring physician that influence the patient and his family?

When the referring physician is generally informed about psychiatric problems he tends to make referrals promptly and wisely. He has an understanding of what is possible and useful in diagnosis and treatment, and what is not possible, or would not be helpful to the patient. He does not expect the impossible nor does he encourage the patient or the family to be unrealistically optimistic. His professional rapport with the psychiatrist is good and he is keenly interested in each patient.

When the referring physician is less generally informed regarding psychiatric problems he may tend to delay or avoid referral. When he does make the referral, he may be unrealistic and lead the patient and family to expect either a diagnosis or form of treatment which is not suited to the specific case. Frequently the working relationship with the psychiatrist is not a successful one.

What are the specific purposes inherent in referral?

The referral may simply be for the specific purpose of consultation; that is, for an opinion by the psychiatric consultant in reference to a specific problem, or, in another sense, for a "psychiatric check-up." After this the patient may be returned to the referring physician, with the psychiatrist's findings, or it may be decided that a second psychiatrist should be recommended to treat the patient in or out of a hospital.

In another instance, referral may be specifically for the purpose of treatment. The referring physician may be entirely correct that treatment is indicated, whatever the diagnosis, and that the psychiatrist to whom the referral is made is the individual he would like to see assume that responsibility. In the event that the psychiatrist cannot do this, it is still likely that he is the one whom the physician would choose to recommend another specialist as therapist, one, of course, who is acceptable to the referring physician.

Some referrals are clearly for the purpose of disposition, in the specific sense of "disposing" of the patient. Many practitioners who are not psychiatrically trained may embark upon efforts to administer psychiatric treatment, only to find themselves in awkward situations, personally irritating, or productive of anxiety both in the patient and themselves. In such instances it is not

hard to identify an unspoken plea, to the effect: "Doctor, for heaven's sake, take this responsibility off my hands. I hope I never see this patient again!" On some occasions such a statement may be made directly and literally to the psychiatrist.

What factors do you consider necessary for successful referral?

An important factor is the complete avoidance of subterfuge or deception on the part of the referring physician in his communications with both patient and consultant. In other words, there is no alternative to his being honest but tactful about saying to the patient that the referral is being made because he feels the patient needs consultation or treatment by an experienced psychiatrist. This explicit understanding must also extend to members of the family who are important in the treatment situation. Naturally, complete frankness about the history and nature of the problem is vital to the consultant's effective participation.

Prompt and adequate reporting by the consultant to the referring physician is of equal importance and should continue periodically until treatment is terminated, regardless of outcome. Such reporting in the case of close colleagues may be done by telephone, but for purposes of record-keeping written reports, as are common in medical practice generally, are preferable.

In psychiatric treatment during which the patient requires additional medical attention, the patient should be returned to the referring physician for treatment, as is always classic practice. If the services of another specialist are indicated, the physician's wishes should be ascertained and a decision made that is acceptable both to him and the psychiatrist.

Another significant factor concerns the psychiatrist's charges. The consultant must be able to adapt himself realistically to a flexible fee scale, so that the referring physician is not handicapped in making the referral by an inflexible attitude toward fees on the part of the psychiatrist.

It is important that the psychiatrist should, not only superficially but with real interest, expect and receive a full medical report on the patient as a sick individual, with full details about laboratory studies and diagnostic procedures. Referring physicians are not impressed by psychiatrists who show no interest in (or even show ignorance of) other aspects of medicine, such as clinical and laboratory findings which may be of direct importance in making a psychiatric evaluation.

Those consultations are usually the most successful in which the psychiatrist is able to handle tactfully the many questions and worries not only of the patient but also those of the family. Thus the referring physician is never subjected to criticism because of his poor choice of a consultant whose lack of tact has antagonized the patient and the family.

How much information should be given the referring physician?

The answer to this question depends again on the nature of the working relationship between the two physicians, especially as related to the psychiatrist's knowledge, based upon previous experience, of how confidentially he may communicate with the referring physician. Or, from another standpoint, it depends upon how much he may be aware of the possibility that the referring physician is likely, because of insufficient psychiatric training, to misuse confidential information. Examples are not rare of physicians, who, upon receiving confidential psychiatric reports, have turned over the typewritten document without further ado to the patient or his family, with literally disastrous results.

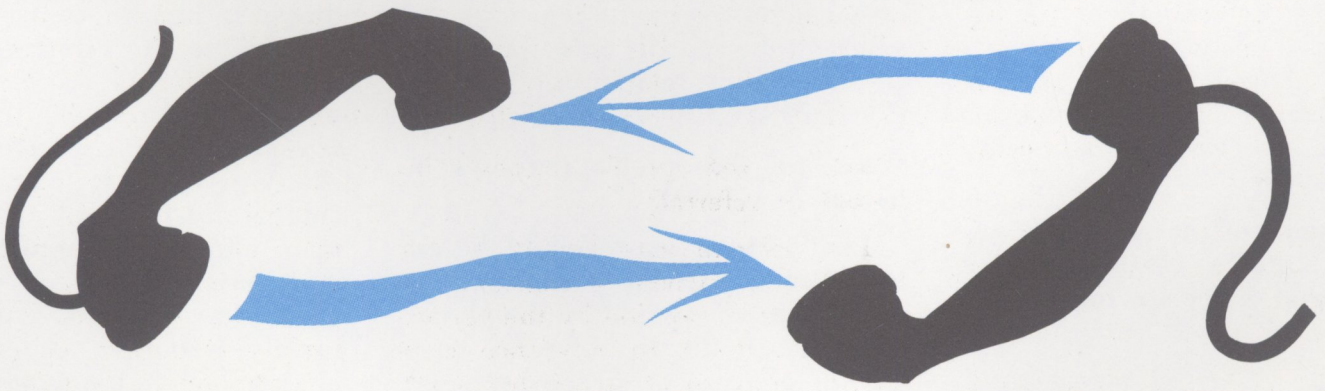
Periodic reporting to the referring physician is necessary to maintain the continued support of the patient's family, as well as that of the referring physician. Certainly the latter is entitled to receive as much information on the patient's progress or lack of progress as is the patient's family.

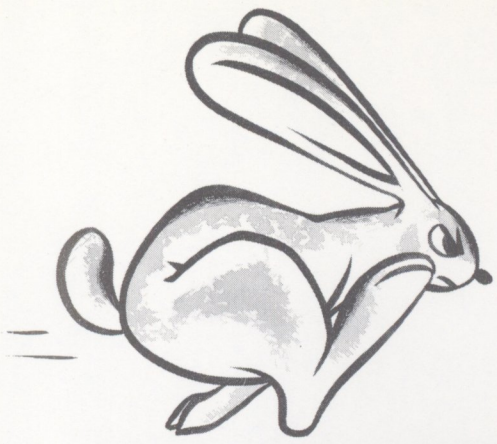
In general, patients are not concerned about the transmission of information about their treatment if they are satisfied that such communication is in their best interests. However, it is good practice to discuss problems in general rather than in terms of specific symptoms, such as compulsive sexual acts and bizarre ideas, and not to reveal identities of other individuals involved in the patient's psychopathology.

Do psychiatric referrals differ significantly from other medical referrals?

In my opinion they often do. Psychiatric diseases and disorders involve the patient's psychopathology, primarily. This fact involves the emotions of the patient's family, both consciously and unconsciously. Frequently the referring physician may also become involved, and, in some cases, the emotional reactions of the psychiatrist may be complicating.

Naturally, emotional responses attend all human interaction in both disease and health, but in psychiatry this feature is dominant. For this reason I believe that there is greater need for personal and professional confidence and effective communication between the referring physician and the psychiatric consultant than in most other medical referrals.





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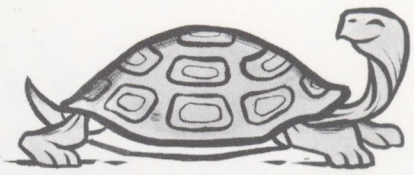

REACTIONS TO DISASTER: In 1956 in a follow-up study of survivors from the Texas City Disaster findings were compared with those of the original survey in 1947. In the earlier survey, few acute psychotic episodes were reported among hospitalized patients. Among the out-patients neuropsychiatric complaints that were seemingly functional subsided within a short period of time. Compensation neuroses were uncommon, and, in general, complainants were believed to have been poorly adapted before the period of the explosions and fire. In the review of patients in 1956 it was found that 43 per cent developed symptoms of functional disorders that were attributed to the disaster. Of 72 patients studied, anxiety was the most often manifested neurosis (61 cases). There were six instances of depression, three of hysteria, one case in which schizophrenia was exacerbated, and one reported child who developed a stutter. Twelve of these individuals were considered to be permanently disabled. Two suicides were considered unrelated.

Blocker, T. G., Jr., et al.: Follow-up Medical Survey of the Texas City Disaster, Am. J. Surg. **97**:604 (May) 1959.

CONTRAINDICATIONS TO PSYCHOTHERAPY: Psychotherapy is not recommended in such disorders as organic dementia, intellectual retardation, severe melancholia, or the toxic-confusional psychoses. As the patient's motivation, possible insight, interest, and verbal ability are highly significant to successful treatment, psychotherapy will obviously be of slight use for the patient who is brought forcibly to treatment or is not personally motivated to change. In patients conspicuously ill in whom mood and behavioral changes are extensive, referral and psychiatric consultation, probably in hospital surroundings, are needed and there is no question, according to this author, of brief or immediate psychotherapy.

Watterson, D. J.: Referral for Psychotherapy, British Columbia M. J. **1**:250 (April) 1959.

PULMONARY EMPHYSEMA: Both physician and patient need to recognize the significance of emotional balance in emphysema. Stress is important in the development and course of the disorder, and the concomitant fear of suffocation creates an even greater emotional reaction. Explanation, candid discussion, interest, and reassurance mean much to emphysematous patients, who require help in adjustment of their life patterns to this particular kind of discomfort. The author points out that emotional tension can precipitate bronchospasm, and the sensations of suffocation frighten the patient severely. Sedatives and tranquilizers if used with caution are helpful in control of the patient's emotions, and psychotherapy is an important adjunct.

Noehren, T. H.: Improvement in the Management of Patients with Pulmonary Emphysema, Geriatrics **14**:274 (May) 1959.

GENERAL PARESIS: A group of paretics were studied after treatment with penicillin and, in some instances, with fever therapy also. In most of the cases there was demonstrable improvement although the signs and symptoms did not wholly disappear, nor did the psychiatric effects of disease. Prognosis for psychotic patients was affected more by the severity than by the type of psychosis. Duration of the psychotic state and duration of the period since the patient had last been able to work at his usual occupation were also important prognostically. Of psychotic patients, the group who were paranoid showed a lower rate of improvement than others but even those patients had some demonstrable benefit. In depressed patients there were "relatively favorable" results. The authors found that in cases of paretic psychosis designated as mild or early more than 80 per cent are suitable for rehabilitation and can maintain the improvement.

Hahn, R. D., et al.: Penicillin Treatment of General Paresis (Dementia Paralytica), Arch. Neurol. & Psychiat. **81**:557 (May) 1959.

TOXEMIAS OF PREGNANCY: From a study of pre-eclampsia, eclampsia, and development of hypertension after the fourth month of gestation the author has postulated an emotional factor in the genesis of toxemia. The significance of pregnancy to the individual patient is important in this respect. Unhappy patients who are ashamed, distressed, guilty, or ambivalent in their anticipation of birth may be more likely to develop toxemia as a means of defense. The toxemia is then "a somatic solution to conflict." Self-punishment of this sort could make the patient more nearly acceptable to herself. The physical disorder can be demonstrated and the physician can help, while the mental discomfort and pain can be concealed. Toxemia of pregnancy is uncommon in schizophrenic patients as their mental defense pattern is established. If it were possible to learn early in the gestation period of a patient's psychological predisposition some prophylactic measures might be devised.

Soichet, S.: Emotional Factors in Toxemia of Pregnancy, Am. J. Obst. & Gynec. **77**:1065 (May) 1959.

MENIERE'S DISEASE: In instances of Meniere's Disease medical treatment is always utilized first and surgery is rarely necessary. With whatever therapy is chosen, however, emotional assistance is of great importance. It is known that circumstances of stress contribute to the genesis of vertigo so that psychotherapy is of literal help in this distressing syndrome. The authors point out the necessity to explain the symptom-complex to the patient and to afford as much reassurance as is feasible. Any environmental situations that act as precipitants should be evaluated. Some relief may be afforded by physiotherapeutic measures as they improve the patient's sense of well-being and may serve as relaxants.

Trible, G. B., and Trible, W. M.: The Problem of Meniere's Disease: Causes and Management, Eye, Ear, Nose and Throat Month. **38**:389 (May) 1959.

SEPARATION

THE PHYSICIAN HAS OCCASION in his practice to observe and evaluate many different manifestations of anxiety. A particular form that is demonstrated by young children and by their parents as well is designated *separation anxiety*. As defined by Robinson and associates this "is a pathologic degree of anxiety experienced by one or both of two people when separation is imminent or actual." It has been described, for the obvious reason, as a "complementary neurosis." Development of the syndrome is considered to be contingent upon emotional immaturity.

Dependency of this type is a product of insecurity and may result from rejection or over-protection by the parent with, in either instance, an element of retroactive hostility. Maternal inconsistency and ambivalence are usually part of the history. Although in the parent-child situation the father is sometimes involved, the problem is ordinarily one of separation of the child from his mother or mother substitute; however, the father's temperament may have affected the formation of the mother-child relationship. This unhappy situation is brought about in some instances by the mother's having felt rejected and unloved in childhood, or by unrealistic attitudes toward marriage and maternity. Often marital dissatisfaction results in the mother's displacement of emotion — whether anger or disappointment or affection—upon the child. Over-protection is one outcome, and the child's whole security is predicated upon maintenance of such care. Sometimes deprivation of one parent by death or divorce heightens the emotional tension between a child and the remaining parent; however, in a child who is psychologically healthy, even bereavement can be experienced without development of neurosis. Three manifestations of separation-anxiety that the family physician may observe in insecure children are those of insomnia, the so-called "school phobia," and invalidism.

Insomnia in infants

In the first few months of life a baby requires, of course, care, attention, and affection but does not necessarily identify the source. In the period of six months to three years of age he does learn, though, to know the person who cares for him. In that period initial indications of separation anxiety may be manifest. Emotional tension in the home affects the child adversely, and may create a circular chain of events. As Anderson points out, the parents, after wakeful nights with the baby, become even more emotional, nervous, or irritable, and the situation is further worsened as parental anxiety exacerbates the infant's fears. There are many possible reasons for infantile insomnia of this type. Babies are affected by erratic schedules, for example, or by changes of circumstance. New faces or altered surroundings contribute to the development of anxiety. Anderson mentions the use of different baby sitters so that the child has no opportunity to get accustomed to one.

In helping parents with this situation the importance of routine must be stressed. Whatever can be done to stabilize the environment will foster a sense of security in the infant. The child should, of course, have his own room. If this is not possible the parents' room should be divided by a screen or partition. Regularity in times for feeding and bathing the baby as well as for putting him to bed will help the child and the parents in mutual adjustment. The presence of the parent or nurse while the child is going to sleep is necessary, and it is equally important for the environment to be peaceful. The

ANXIETY. .

parent who is urging the child to go to sleep or threatening him is not helpful. A parent who is fidgeting and eager to escape only contributes to the child's wakefulness. The mother who can sit quietly and peacefully in another part of the room has a reassuring effect. According to Anderson the parent should continue to sit for a half hour to an hour after the child has fallen asleep during the adjustment period. If the restless infant who is a light sleeper wakes in a few minutes to find himself alone, the dread or fear of sleeping will be severely aggravated. To create a situation of calm and of trust, and to alleviate fear, this kind of routine can prevent a lasting problem of severe anxiety.

School phobia

There is sharp disagreement among investigators as to the propriety of the term "phobia" in cases in which a child cannot be separated from his parent to go to school. Wallinga, among others, has pointed out that the child does not fear school as the term would imply. The disturbance is occasioned by the prospect of separation. This manifestation does not mean simple reluctance, homesickness, dislike of study, or shyness. With school phobia the child finds it intolerable to be separated from his mother—to the extent of illness, failure in school, and actual neurotic behavior. Often, separation is unwelcome to the mother, too.

Suttenfield finds this to be a truly phobic reaction in that the anxiety is displaced and a symbolic object of fear is chosen. Whether such disturbance is called a phobia or a "variant" of the separation anxiety, it is a specific emotional disorder that is lately being more frequently diagnosed. School phobia is unrelated to truancy, as the motivation is different. Truants are purposefully absent from home as well as school usually, and are characterized by aggressive traits. The child that is burdened with separation anxiety has fewer secondary gains from the situation. He wishes only to be at home or, at least, in the protective society of the parent.

The age group in which school phobia is most often reported is between six and ten years, the first few years of formal schooling. Starting to school creates some degree of anxiety in all children, but the emotionally healthy ones adapt fairly soon to the routine. In children who cannot adjust the parents often augment their fears or provide them with reasons to dread school or to defer going. Both children and parents tend to rationalize the reaction. In some instances a child may be afraid that his mother will die or simply leave during his absence. Others fear to leave home because a younger sibling will then have unchallenged possession of the mother's attention. Such feelings are expressed, though, as fear of the teacher or of failure, or the mother may mention apprehension about infectious diseases, storms, or accidents en route. Some parents relate stories of their own childhood fears or use threats of absence or of sending children away as disciplinary measures.

Before any treatment program is undertaken it is important to determine how serious the disorder is in the particular child. One criterion is the degree in which other areas of the patient's life are affected. It is important to know his other manifestations of anxiety, whether in other aspects of his social life he is similarly disturbed, and if he relates at all successfully to other children. Extremely ill children rarely enjoy any social activities, and their guilt and anxiety keep them depressed and self-critical. Therapy is necessarily directed to both mother and child.

The physician can in conversation and in taking the history ascertain sources of stress and emotional tension in the family background. Children in whom the phobic reaction is extreme will require definite psychiatric help. In children less seriously involved the physician may want to enforce schooling, even if for limited periods, during therapy. A young child that can be helped or made to attend school and absent himself from his mother even for periods of less than an hour may begin slowly to take some pride in becoming able to stay for longer periods. Meanwhile the parent, also, is overcoming some difficulty, too. Obviously in some children compulsory attendance would be unwise if there is any likelihood of precipitating more serious illness. At this time the physician in talks with the child alone can encourage any evidence of independence at all. In his talks with the mother he may hope for some development of insight as she explains and discusses the child's problem and her own. In encouraging the patients to talk freely—and separately—the physician can learn quickly what aspects of the relationship are significant, as, for instance, in the subjects the child will discuss in his mother's absence as opposed to those which he can mention in her presence. The physician may find it expedient to bring the other parent directly into the treatment program, and, at such a time, the school personnel can be of appreciable help too, if they understand the nature of the problem and the proposed means of gradually separating the child from his home situation. Eisenberg points out that if a child is allowed to remain at home his regression is reinforced, while making him go to school implies confidence in his ability to adjust to the school situation.

Prognosis for younger patients is good, but it is significantly less so if the child is in the adolescent age group. A child whose anxiety is so great that he resists the natural adolescent urge for independence is chronically ill indeed and there is less likelihood of success with a short treatment period. In a report by Wallinga 21 children, five of whom were adolescents, received psychiatric treatment for school phobia. Of these patients, the children between the ages of six and eight years required an average of five interview sessions to resolve their anxiety, while an average of 15 interviews was needed for the nine- to eleven-year-old patients. Adolescents were under treatment for periods of several months.

Whether treatment is conducted by a psychiatrist or by the family physician it is necessary that more be accomplished than simply returning the child to school. This is first, of course, but it simply amounts to alleviation of only one symptom. Some change must be made in inter-family relationships so that the child can adjust to the demands of maturation.

Invalidism

Jensen has said that children have only a few ways by which to solve their emotional problems. One of them is by becoming ill and thus avoiding any situation that they are unable to manage healthily. Onset of assorted psychosomatic disorders is predictable in children with separation anxiety. Absence from school is ordinarily excused by the individual's not feeling well enough to go, and it is literally true, in these cases, that the child is sick. The way is, in a sense, prepared for development of psychogenic ailments, as often the parents are oversolicitous, and sometimes there is evident a form of displaced hypochondriasis.

Gastrointestinal disorders are common, with nausea, vomiting, and abdominal discomfort among the frequently reported ailments. Johnson describes instances in which children became severely ill, lost weight and appetite, and sometimes were confined to bed for periods of as long as three months. Such patients are frequently described as neurasthenic. Addison's disease is often suggested or some comparable systemic malady. In many instances the mother has encouraged regression. The child's dependency answers the parent's need for security, and the child, in this manner, purchases affection, attention, and relief from guilt.

In a 14-year-old patient reported at the Mayo Clinic, hospitalization had become necessary, and trichinosis, Addison's disease, electrolyte imbalance, and brucellosis had all been suggested as causative. When it became apparent that the disorder was of emotional origin the child and her mother were both placed under intensive psychotherapy. Despite the severity of separation anxiety the results were favorable and the child was able to return to school. In less severe instances the physician will first afford symptomatic relief and administer such medication as the illness requires, but he will also work toward clarifying the emotional situation so that the pattern of symptom development will not be maintained.

In cases of separation anxiety the physician's attitude is of paramount importance. It is necessary for him to inspire candor and trust in these patients, as well as for him to be both firm and encouraging. It is unwise for the physician-patient relationship to become personal to any great extent on the child's part, as anxiety may then result at separation from the physician at the end of treatment.

Conclusion

Johnson says that the principal cause of neuroses in a child is his living with parents who are neurotic. It is important for the physician to evaluate the family circumstances and interaction if he is successfully to treat a child in whom separation anxiety is manifest. Rejecting or ambivalent parents delay the child's normal emotional maturation. For these insecure patients environmental stability is needed. Unless the ego can be reinforced separation anxiety in childhood can be the basis of serious neurosis in the adult.

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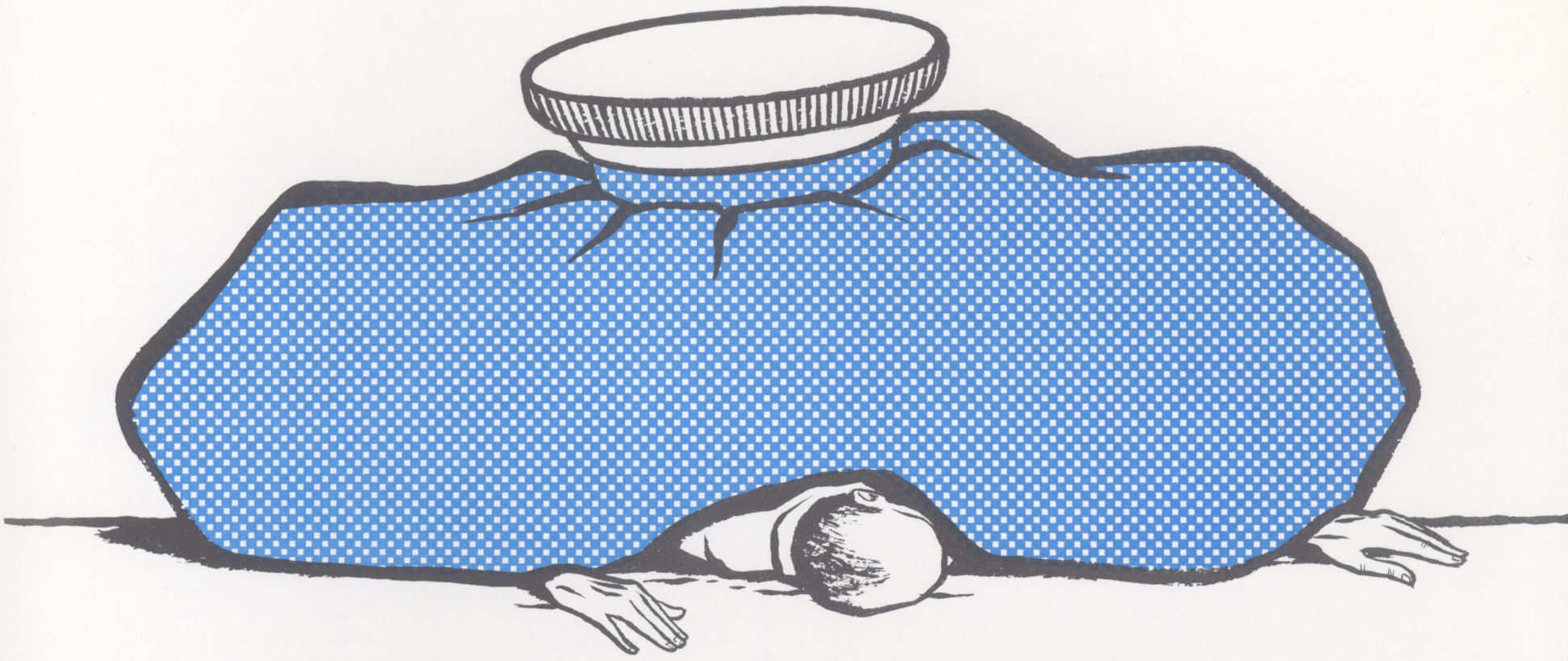

The Katzenjammer

The hangover, in addition to chemical toxicity, includes signs and symptoms of emotional conflict and constitutes the optimal time for beginning psychotherapy

The graphic terms that are used to describe the aftermath of alcohol consumption are obscure in origin. Some dictionaries include *katzenjammer*, and in other sources the expression "the morning after," in quotation marks, is cited. Sometimes the word *hangover* is given this secondary meaning. In this sense, and as slang, the word was in popular use in the United States by 1912, at least. *Hangover* has long since been adopted for use in connection with other over-indulgences, such as smoking or drug-taking, but lexicographers have not yet conceded it as medical usage nor afforded an appropriate substitute, with the exception of *katzenjammer*.

Symptomatology

Signs and symptoms of this misery are also poorly defined. Headache, malaise, gastritis, vertigo, functional neuritis, anorexia, dyspnea, palpitations, gastric catarrh, tachycardia, fatigue, chills, thirst, nausea, tremor, fever, and cold sweats are common complaints. The language of alcoholism is colorful in its slang, for example, in such a term as "hot coppers," listed in some dictionaries as a synonym for katzenjammer. The phrase "hot coppers" refers to the sensation of hot parched dryness in the throat that accompanies dehydration. These cited complaints are general, however, and individually much more bizarre disorders are reported. Emotional or psychologic ailments are more nearly uniform among different patients. For instance, almost all experience guilt, fear, and anxiety, sufferings not strictly separable from physical distress. More acute conditions exist, seemingly, in the more neurotic patients. To Karpman, the evidence afforded by the hangover clarifies the difference in the controlled or occasional drinker and the uncontrolled chronic alcoholic, because in the hangover there is a sort of dramatization of the psychodynamics of alcoholism for that individual.

This physician describes as one example the so-called social drinker whose hangover is mild, insofar as it is largely a somatic reaction. It may even be a matter of some small degree of pride, evidence that the person is tolerant, human, and fallible, too. At the other extreme of dipsorrhexia are consistent drinkers with such discomforts as fugue states, delirium tremens, blackouts, or acute illness. By stages, the alcoholic progresses until the hangover experience is almost wholly an emotional one. Predominantly physical reactions are discarded in this progression, or, more properly, subordinated, along

with, unfortunately, the usefulness of medical agents to alleviate them. The alcohol is not directly causative of all of the psychiatric symptoms but is, instead, part of the mechanism of the release of these symptoms.

The physical factors

The hangover is emotionally-prepared, but this does not exclude contributing elements that are demonstrably physical or chemical. That alcohol can have enduring toxic effects is certainly well-known, and that the types of alcohol, times of ingestion, and physical status of the drinker contribute. Recent reported studies of contaminants have shown that there are properties or congeners that augment some of the less comfortable developments. For instance, acetaldehyde and isoamyl alcohol are believed to be pharmacodynamically harmful. Actually, quality of the alcohol may have more effect on duration and intensity not only of the "drunk" but of the hangover, too, than the amount consumed.

The headache has been attributed to dilation of cerebral and pial arteries and, sometimes, extracranial vessels. Wolff points out that, leaving aside psychologic factors, it is still true that laboratory demonstrations are not really similar to social or private drinking. He suggests that although cranial vasodistention exists, the alcohol is only indirectly causative of the discomfiture. He mentions, besides the known emotional elements, the excitement, loss of sleep, and unrestrained activity.

Onset and duration

The hangover is *not* a convalescent period. Most alcoholics consider it as a state of ill-being that begins some hours after the termination of drinking, usually after a period of sleep. Karpman predicates an onset that is somewhat earlier.

It is established that originally alcohol intake relieves depression and reduces or "narcotizes" anxiety. For those reasons alone habituation would be common. The consumer is exhilarated or relieved of responsibility or of some inhibitions. Because alcohol is a depressant, hoped-for effects ultimately wane or become unattainable, and the alcoholic depression is superimposed upon the neurotic one. To Karpman that is the literal beginning of the hangover. He has compared the debauch and the resultant shame, fear, and anxiety to the epileptic seizure, even to the extent of "exhausted relief" at the termination. If the entire time of inebriety and not just the hangover is considered there is a resemblance between the conditions that is not wholly figurative. Occasionally alcoholics experience a preliminary sensation similar to the aura. In pathologic intoxication there are disorders of consciousness that, in the opinions of some neurologists, are manifestations of psychomotor epilepsy, and epileptiform convulsions do occur in delirium tremens.

Duration of the hangover varies greatly, sometimes in proportion to the amounts of alcohol ingested. In advanced alcoholics suffering ends only when drinking is resumed, which is to say that there is never a "free" period. Relief of bodily misery is no real end to the hangover because the emotional reactions are worsened at that time. Alleviation of discomfort by further drinking is also affected by the fact that anxiety, anger, and guilt are perpetuated and exacerbated in the hangover. At the same time the escape into fantasy is continued, with what is described as "disregard of reality."

Personality factors

One aspect of depression, in Fenichel's words, amounts to loss of self-esteem which the individual tries to negate. In actuality he aggravates this loss. In seven men and seven women patients reported by Karpman, environmental factors seemed to have little to do with development of chronic alcoholism. In these patients flight from conflictual emotions coexisted with convictions of inadequacy. The male patients were more often aware of maladaptation, while the women assigned their problems to external causes or situational stresses. In this group more background material was obtained about the men. In six of the seven there was evidence of homosexual conflicts. Too few personal data were obtained from the female patients for comparison in sexual adaptation. The male patients more readily admitted insecurity and emphasized to a greater extent the emotional misery. The women described in more detail the physical symptoms, although they also considered them subordinate to the mental anguish. Fear and loneliness were common to both groups and all of the patients were remorseful. An alcoholic patient after psychoanalytic treatment said, ". . . one's conscience is at its lowest ebb in the hangover."

The patient referred to was cured after psychoanalytic treatment. According to Noyes, however, psychoanalysis is rarely suitable, as alcoholics are unstable, emotionally, and can only poorly tolerate stress.

Psychodynamics

Fenichel has described Simmel's findings with drug addicts, and his words apply to alcoholic personalities also. First, he refers to "artificial mania," then to the "objectless" alternate elation and depression, and, finally, to the "increasing insufficiency of the elation." The circle becomes more than ever vicious and, at last, "lack of effect increases the longing." In that particular understatement the situation is summarized. Whether intoxication is expressed as dissolution of the superego or the divesting of ego-alien material, the individual finds in it freedom from outer or inner frustrations.

Menninger, in a discussion of reaction formation, has referred to the discrepancy between conscious and unconscious wishes. When, in a state of intoxication, control is relinquished, unrecognized desires are manifest, or the unfamiliar and primitive self. In the hangover the individual emerges, possibly with an incomplete recollection of it, from an exposed state, so to speak. His rage, distress, or fear is a continuation or representation of his same personality, drunk or sober. However the procedure is explained, the cyclic state that is reached—better described as spiral—makes repetitive overindulgence necessary. With physical disorder, fear of consequences (social or legal), and the same inability to meet whatever situation he could not meet the day before, he re-enacts in his sufferings the less pleasant phases of inebriety.

This is the state in which treatment is begun. Because all therapy must be conducted in periods of abstinence, and because, for the alcoholic, all such times are attended by

the misery of withdrawal, it may be said that psychotherapy must, perforce, be undertaken during a hangover. Immediate effects may have been assuaged but the emotional ones are not yet eradicable. At such times restraining or coercive procedures are unwise, as they provoke irritability, hostility, and resentment.

Remedies

A truly impressive collection could be made of popular remedies. It would include many prophylactic measures—such as ingestion of milk or olive oil before drinking—indeed, anything but the obvious one of abstinence. For the morning after, carbonated beverages, tea, fruit juices, coffee, food, aspirin, emetics, massage, and sodium bicarbonate are often mentioned. And all of these have nothing to do with the so-called hospital remedies, such as paraldehyde, tranquilizers, and other agents. Of remedial measures taking of another alcoholic drink or combination of drinks, particularly during nausea, is historically the best known. The expression "the hair of the dog" was already in popular use in the 16th century. Symptomatic relief is not easily achieved, and has no effect at all towards averting future drinking. It is not surprising when the local drunkard becomes the local drug addict. To substitute one outlet for another is common and singularly unhelpful. Actually, treatment in hospitals or special sanitaria is often only supervised withdrawal.

The neurosis that prompted or that constitutes the alcoholism is the important element. Thus, to ease the discomfort is both necessary and futile. Momentary relief is needed but it is, of course, the addiction that requires attention. Efforts to cure can only be directed toward the addicted patient's emotional status. The unwilling individual can rarely be treated successfully, and most alcoholics are in that category. As Bartemeier has described them, "They are victims of a slow and prolonged suicidal process."

The alcoholic who is threatened or coerced into the physician's office is an unlikely subject for successful rehabilitation. The characteristic immaturity does not usually prompt a sincere decision to overcome the problem. Strecker has discussed the importance of the physician's maintaining an adult attitude and refusing to permit a personal attachment to develop. Objectivity and candor are essential for the physician who attempts psychotherapy; nevertheless, interest in the well-being of the patient is needful if he is to discuss problems or receive any assistance.

Points in psychotherapy

1. Evaluation of the individual patient comes first, as therapeutic emphasis will be on the person instead of the alcoholism *per se*. In cases of obvious disturbance of behavior or distorted thinking psychiatric evaluation will be needed. The patient's traits, attitudes, and behavior when sober are significant in determining his emotional competence.

2. Second, for establishment of the treatment situation the patient has unequivocally to concede the diagnosis. He has also to recognize that abstinence is imperative and that there can be no compromises. This is not a matter of making a set of promises, which the alcoholic has usually done too often, but is instead a condition of treatment. The patient has to let the physician know of his failures or relapses. Strecker points out that if backslidings occur physician and patient will go over together the circumstances that prompted a resumption of drinking.

3. If the patient is to achieve any sort of emotional maturity, two sorts of discussion are really involved. He will have to vocalize his emotionality instead of hiding or accumulating strong feelings of anger or anxiety. Besides, he will have in his talks with the practitioner to rid himself of his own means of self-deception and the many rationalizations that he has had to utilize. He has, actually, to comprehend both the reasons for his alcoholism and the reasons why he is in treatment. Strecker points out that the reasons a patient gives for wanting to stop are often seemingly sincere while wholly false, and serve as "sops to his belittled and shamed ego." Remorse is real but not curative and usually sends the patient to more alcohol instead of to the physician.

4. With the alcoholic patient procedure will differ from the suggestions that will probably have been made previously for his betterment. He will not be encouraged to forget or put behind him his distresses or misdemeanors. Instead, he will be expected to remember them in as much detail as he can. By reexamination of these episodes it may be possible to improve the patient's understanding and thus to further his long-delayed maturation.

5. In helping the patient to adapt to his future-without-alcohol, whatever environmental adjustment will be useful must be honestly considered. Support from the patient's family is important, but regrettably is often presented adversely. Suspicion, nagging, or cajoling may encourage further dependency or may alienate the patient. The physician's attitude of impersonal interest and his lack of condemnation help to make the patient see himself as adult. For this reason, among others, the physician's approach is separate from moralizing or from emotional appeal.

6. Last, the physician should be

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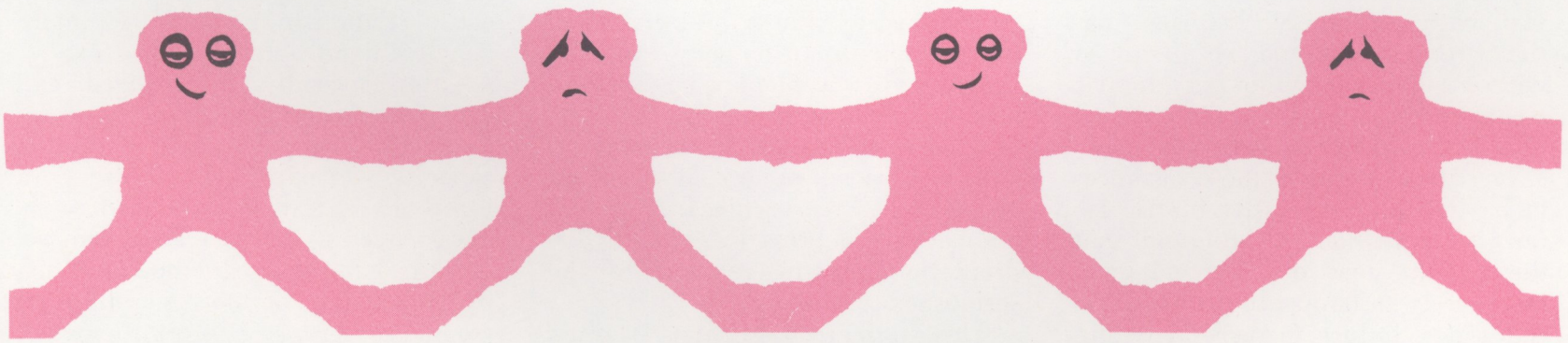

Depression in Constitutional Disorders

Most patients with chronic constitutional disorders manifest some degree of depression. The depression may be readily apparent, or thinly disguised, or even denied by the patient. Contributory factors are numerous and include inability to work, loss of income, change in family relationships, or enforced immobility. In certain cases there are additional threats to peace of mind, such as fear of death or of mutilation from an impending operation, or change of body image as a result of disability.

To the extent that the physician recognizes that depression exists and understands its possible causes, he is better able to hasten recovery and minimize residual effects. With a well-adjusted patient, only minimal, superficial psychotherapy is needed. When emotional reaction is neurotic and interferes with rehabilitation, psychiatric referral may be indicated, and with extremely disturbed patients referral should be arranged without delay. While psychiatric treatment is being given, the physical illness should not be neglected.

Leinbach considers these instances to be indications for psychiatric referral: depression so profound that the patient does not respond even moderately to happenings in his surroundings, failure to respond within a few weeks to therapy provided by the nonpsychiatric physician, prolonged depression, depression that is intrinsic rather than situational, and family history of suicide or admitted thoughts of suicide, or both.

Emotions and attitudes are often more incapacitating than real disability. Bellak was impressed that depression in tuberculous patients was directly related to the patient's own concept of his illness. Therefore, he believes that one of the physician's first duties is "to investigate the superficial meaning of the illness for the patient, in common sense terms, and to tell him that the circumstances of his neighbor's or relative's illness were not the same as his own." Misconceptions can be extremely troublesome if they are not corrected.

Schilder defined the organic picture which the patient has of his body as the *body image*. This image may be changed by illness, and, if related to a specific organ or body function, the altered concept may be emotionally charged. Psychologically, certain parts of the body represent organs of especial value. Thus, lesions of the eyes, breasts, heart, or sexual organs may depress the patient disproportionately in relation to the seriousness of disease.

The stigmatization that is often associated with severe bodily distortion or physical limitation can cause severe depression. Some disabled patients cannot conform to established social standards, and even a less obviously affected patient may believe that his social life suffers because he cannot maintain his former pace. Not infrequently, his friends are unable to bear his suffering and misfortune, or they become embarrassed by continued association with a handicapped person. Other associates may withdraw because they fear that excessive demands will be made on their time and energy. Thus, the patient may eventually be forced to seek companionship among other handicapped persons. Nevertheless, several compensating factors can be emphasized. New friends may be more understanding, more faithful, and more challenging, and greater personal closeness may be possible because friendship is based on more penetrating insight.

Pain, especially if prolonged, can cause the patient to be unduly depressed. Each patient has a unique capacity for pain. When the pain threshold is low, any pain may be experienced as severe. Furthermore, if pain is prolonged emotional disturbances may be more serious than would otherwise be anticipated.

Therefore, special attention is required. In addition to medication for alleviation of pain, the physician should give the patient all of the psychological support necessary to achieve the capacity to tolerate pain. Failure to receive this support causes the patient to lose confidence in treatment, reduces his motivation for recovery, and increases disability.

In some chronic diseases, restriction of movement is necessary for prolonged periods. Even though current medical practice is to encourage early ambulation, some patients will have only minimal ability to move about. Others will be confined to bed for long periods, perhaps even permanently. They are thus denied the relief for pent-up emotions afforded by movement which is fundamental to many persons. Unnecessary restriction of activity should be avoided. Patients are more likely to accept restricted motility if their emotional difficulties are reduced or removed. In this endeavor, the physician is often able to provide adequate psychologic support through use of ancillary personnel. Medical or psychiatric social workers are sometimes able to help resolve problems that trouble the patient because he is no longer ambulatory. In addition, emotional outlets may be afforded through conversation, constructive learning activities, and vicarious experience provided by reading or by television and radio.

Family relationships which were poor before illness or which have been greatly disturbed by it are other sources for depression. If the patient's spouse is openly hostile, or if the marriage is what Sutherland terms a "facade marriage," the patient expects, and perhaps receives, little help. Other problems may also exist. For example, if the patient was the one about whom the family's activities revolved, both he and his relatives may need assistance in readjustment to illness. Nevertheless, in general, if family relationships were good previously, they usually continue to be good and are assets to the patient. If poor, they usually deteriorate and may prove detrimental. Sometimes social workers or family agencies can provide considerable help.

Acceptance of economic hardships is one of the most difficult adjustments to make in the course of chronic illness. Few patients have incomes independent of salary, and insurance coverage may be inadequate. Many aspects of this problem may be complex, such as the need for dependents to work, acceptance of charity or government assistance, or placement of business affairs in the hands of someone whose competence or loyalty is questionable. Such matters cause insecurity and worry and have adverse effects upon the patient's mental attitude. Nevertheless, he may "overlook" such problems because they seem overwhelming or because he feels that nothing can be done. The physician may be guilty of the same oversight if he is

unfamiliar with the situation or if he is concerned with more immediate and more obvious problems.

Therapy

With increased understanding of the potential causes of depression, the physician will be better able to direct the removal of unfavorable environmental factors and to offer effective psychotherapy appropriate to the individual patient. Fortunately, most patients with chronic constitutional disorders show a reactive depression which does not interfere greatly with interpersonal relationships or rehabilitation. Even when complete recovery is unlikely, superficial, supportive psychotherapy and other psychologic assistance will help to avert serious mental illness and greater physical disability. As a result, many patients will tolerate their physical difficulties better and show greater interest in their rehabilitation.

A positive rehabilitative program with realistic goals for the patient that is instituted early in the course of treatment is a powerful deterrent to development of depression. It forces the patient out of despondency and passivity and instills in him the feeling that those around him are interested in his well being and return of function. He no longer feels that he is a useless burden. A planned program of vocational counseling instituted in the earliest part of illness will give the patient hope and courage and inspire him to use his time profitably instead of in psychically self-destructive inactivity.

Some physicians are reporting encouraging results with the use of ataractic drugs in mildly depressed patients. Any improvement noted is only symptomatic, however, and occasionally depression is increased rather than alleviated. These preparations have been used in combination with such anti-depressant substances as amphetamine and compounds of piperidine structure. Recently, also, meprobamate and benactyzine have been used in combination (Deprol®) with success. The latter agent is a mild anti-depressant. Iproniazid (Marsilid®) has been effective in the control of depression in some patients, but frequently produces undesirable side effects, including agitation and liver damage. It must, therefore, be used with extreme caution. Final evaluation of newer drugs such as these for the relief of depression must await further clinical trial.

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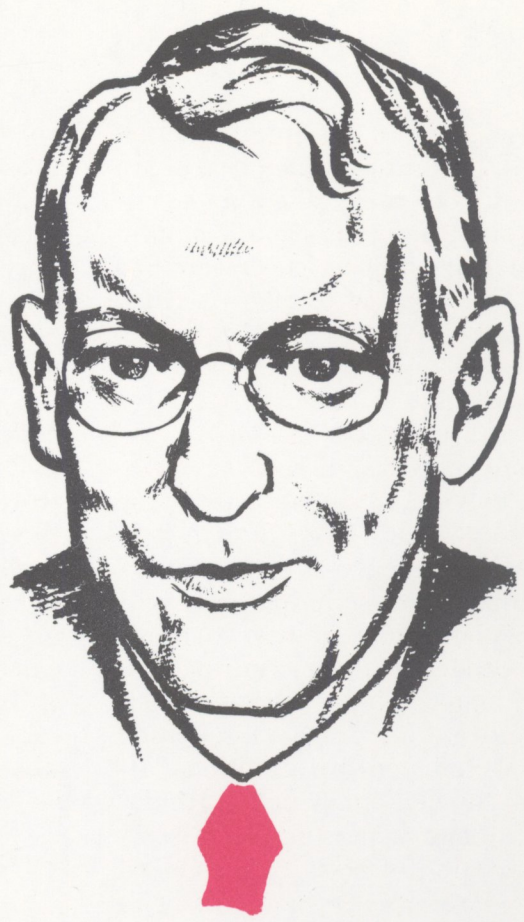
Edward A. Strecker, M.D.



SOON AFTER THE UNITED STATES entered World War I, First Lieutenant Edward A. Strecker of Philadelphia was assigned as divisional psychiatrist with the 28th (Pennsylvania) Division of the American Expeditionary Force. During his service with the unit, both in the States and in France, he developed an enduring interest in military psychiatry that lasted throughout his lifetime. For his unique accomplishments in this field of endeavor, he received many honors, including presidential recognition and citation from the Selective Service System and from each of the Armed Forces.

As a result of his experience during World War II, Strecker concluded that there had been a dangerously high rate of induction rejectees and of medical discharges for neuropsychiatric reasons. Almost two million men were rejected for military duty on this basis, and this number comprised about 40 per cent of total rejections. Furthermore, during hostilities the Army released soldiers with neuropsychiatric diagnoses at at rate of 30,000 per month for a total of 600,000 discharges. Approximately half a million men had attempted to evade the draft.

Strecker compared the frequency of neuropsychiatric diagnoses among military personnel during the two World Wars. During the earlier conflict, the most common neurosis was conversion hysteria, and, during the latter, anxiety reactions. Strecker stated that "we have come perilously close to the saturation point of human emotions, and that while there may be no limits to the resources of engineering genius in perfecting machines of war, there is a limit to the capacity of human emotions to survive the psychic devastation and degradation which is produced."

Most significant in the prognoses of servicemen with disabling neuropsychiatric conditions, Strecker believed, are these factors:

1. The better the personality and the sounder its integration before the casualty, the better the prognosis.
2. The shorter the period between onset of illness and initial therapy, the better the prognosis.
3. Within limits, the nearer to the battle line the patient is treated, the better the prognosis.
4. The more severe the extraneous factor, as, for example, exhaustion, deprivation, or acute emotional stress, the better the prognosis.

Strecker was one of a committee of three appointed in 1942 by the American Psychiatric Association to study and make recommendations with regard to the place of psychiatry in military medical programs. In the Spring of the next year, while serving as President of the Association, he was named psychiatric consultant to the Secretary of War for the Army Air Forces and to Surgeon General Ross T. McIntire for the Navy. Later that year he was on a board of five outstanding physicians appointed by President Roosevelt to investigate and report on medical requirements for entry into the armed services. Strecker was instrumental in establishment of a Navy course in Philadelphia, which was able with cooperation from the city's five medical schools to give some basic psychiatric training to 250 medical officers within a relatively short period.

As an indication of his wartime prestige, Strecker was assigned a room in the White House when he wished it, and, as one of a medical committe, a room in General Eisenhower's London suite. On January 16, 1948, he was awarded the Presidential Certificate of Merit in recognition of his services as consultant to the Surgeon General of the U. S. Navy. Formerly Chairman of the Committee on Psychiatry of the American Red Cross, he also served as senior consultant to the Veterans Administration, and consultant to the U. S. Public Health Service.

Strecker was Professor of Nervous and Mental Diseases at his alma mater, Jefferson Medical College, from 1925 until 1931, at which time he became professor and head of the Department of Psychiatry at the University of Pennsylvania School of Medicine. He served continuously in

that capacity until 1953, when he became professor emeritus and was sponsor of the Strecker Psychiatric Society there. He was Clinical Professor of Psychiatry at Yale from 1926 to 1932, and first professor of psychiatry at Seton Hall College of Medicine and Dentistry in Jersey City.

A prolific writer, the noted psychiatrist was author of 200 medical articles and of several outstanding textbooks. *Practical Clinical Psychiatry*, written in collaboration with Ebaugh, Ewalt, and Kanner, had eight editions, and *Basic Psychiatry* and *Fundamentals of Psychiatry* each had five. Appel was his coauthor for three books, *Examination Handbook*, *Discovering Ourselves*, and *Psychiatry in Modern Warfare*.

Strecker gave several important lectures, among them the Thomas William Salmon Memorial Lectures in psychiatry and mental hygiene in New York and London, the Menas Gregory Memorial Lecture in New York, the Bernard McGhie Memorial Lecture in London and Ontario, the 17th Pasteur Lecture in Paris, and the Jieracki Lecture in Philadelphia. On May 24, 1944, he received the Strittmatter Award of the Philadelphia County Medical Society for distinguished service in psychiatry and mental hygiene. He also was awarded the Shaffrey Medal from St. Joseph's College (Philadelphia) Medical Alumni Association. A building dedicated in 1957 at the New Jersey Neuro-Psychiatric Institute was named for him. Strecker died on January 2, 1959, at the age of 72.

Suggested Reading

Bond, E. D.: In Memoriam: Edward A. Strecker, M.D., 1886-1959, Am. J. Psychiat. **115**:959 (April) 1959.

Edward Adam Strecker, Obituary Notice, J. Am. M. A. **169**:1223 (March 14) 1959.

Smith, L. H.: Edward A. Strecker, M.D., President 1943-1944; A Biographical Sketch, Am. J. Psychiat. **101**:9 (July) 1944.

Strecker, E. A.: Fundamentals of Psychiatry, Philadelphia, J. B. Lippincott Company, 1947, p. 265.

Strecker, E. A.: Military Psychiatry World War I, 1917-1918, in Hall, J. K., et al., (eds.): One Hundred Years of American Psychiatry, New York, Columbia University Press, 1944, p. 385.

Strecker, E. A.: Their Mothers' Sons, Philadelphia, J. B. Lippincott Company, 1951, p. 5.

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THE KATZENJAMMER

Continued from page 75

aware of the risk of countertransference. In most instances, alcoholics are ingratiating persons who will sense what the physician wants to hear and then tell exactly that, regardless of any untruths involved. These individuals are disturbed and will try to inveigle the physician into a personalized relationship by appearing to perform as expected.

Of social adaptive measures change of work is often suggested. Actually, as far as a remedy, this is seldom of any use. It may be possible, though, that the nature of the occupation is conducive to anxiety, in which case the patient might need vocational counseling. Minor changes in the milieu, while not curative, may help in breaking the pattern. A new avocation, a different neighborhood, or another car pool may divert the patient or attract his interest, although none of them will stop him if he chooses to resume drinking.

Conclusion

In treatment of the alcoholic, symptomatic relief has first to be afforded. Judicious withdrawal is, of course, essential, with prolonged psychotherapy for two purposes. First, it is important to achieve withdrawal without precipitating psychotic developments when the patient's "prop" is removed, and, second, the neurosis that necessitates the flight into alcohol is still the primary problem. While such repair as is feasible is provided for the patient's physical being, psychiatric care should be intensive during what will, if therapy is to be effective, amount to his longest and most difficult hangover. Alcoholics are not easily treated. Their obstinacy and duplicity are well-documented. It may be that these factors account for the weakly-disguised cruelty that is sometimes displayed in their professional care. Nevertheless, it is indeed rewarding when they can really be rehabilitated and not just "sobered up."

Sometimes in these orally-dependent cases the attention given them by hospital personnel and the concern of the physician afford sufficient substitute for alcoholic gratification. This has, of course, its dangers in development of another sort of dependency. With alcoholic patients it is preferable for the stay in the hospital to be brief and the overcoming of addiction to be accomplished on home grounds. Karpman has suggested that the consumption of alcohol provides a mask to cover the scars and ravages of neurosis. The cycle includes exposure and the pain of the hangover. If the disfiguration is removed, though, the mask is no longer needed.

Suggested Reading

Bartemeier, L. H.: The Management of Overeating, Overdrinking and Oversmoking, in Psychiatry for the General Practitioner, Seminar presented at Princeton University, April 17, 24, May 1, 8, 15, and 22, 1957. Philadelphia, Smith Kline and French Laboratories, 1958, p. 34.

Fenichel, O.: The Psychoanalytic Theory of Neurosis, New York, W. W. Norton & Company, Inc., 1945, p. 378.

Karpman, B.: The Hangover, Springfield, Charles C Thomas, 1957, p. vii.

Menninger, W. C., and Leaf, M.: You and Psychiatry, Charles Scribner's Sons, New York, 1950, p. 121.

Noyes, A. P., and Kolb, L. C.: Modern Clinical Psychiatry, 5th ed. Philadelphia, W. B. Saunders Company, 1958, p. 191.

Smith, J. A.: Psychiatric Treatment of the Alcoholic, J. Am. M. A. **163**:734 (Mar. 2) 1957.

Strecker, E. A.: Psychotherapy in Pathological Drinking, J. Am. M. A. **147**:813 (Oct. 27) 1951.

Tunis, M. M., and Wolff, H. G.: Varieties of Headache and Their Mechanism, M. Clin. North America **38**:673 (May) 1954.

Wolff, H. G.: Headache and Other Head Pain, New York, Oxford University Press, 1948, p. 200.

The Congeners, Time **73**:72, 1959.

BOOK REVIEWS

• DREAMS IN FOLKLORE. *By Sigmund Freud and D. E. Oppenheim, translated by A. M. O. Richards, and edited by James Strachey. Pp. 111. Price $3. New York, International Universities Press, Inc., 1958.*

Only in the last few years was the existence of this paper, written in 1911, realized, so that with its translation and publication a new item is added to the bibliography of Freud's works that are still extant. The essay is one that Freud had felt needed writing, and his invitation to Oppenheim is an interesting addition to what is known of Freud's character. The essay is a short one—only 45 pages long, and in this book both the German and the translated versions are included. The work is obviously unpolished, and, as it was handwritten, some of the references and notes had become illegible by the time translation was attempted.

The correlation of folklore materials and the psychoanalytic interpretation of dream symbolism is a real one, and, in the author's opinion, the indecent, scatological, or pornographic content should not prevent study of such materials. Human desires and needs, however phrased or expressed, are a serious and immediate matter in the understanding or the therapy of troubled individuals.

The preface to DREAMS IN FOLKLORE is by Bernard L. Pacella, M.D. There is an introduction by the editor, and a letter from Freud to Oppenheim is included.

• CENTAUR. *By Felix Marti-Ibanez, M.D. Pp. 714. Price $6. New York, MD Publications, Inc., 1958.*

The historical development of medical ideation furnishes a colorful story, with sufficient variety, surprise factors, and philosophical portents to interest almost any imaginable reader. CENTAUR is a collection of essays that can afford information, curiosa, humor, and delightful reading, as well. The diversity of interests and talents that characterize Marti-Ibanez and his writings stand him in good stead in this informative volume. Some of the articles are reprinted but all of them will bear reperusal. CENTAUR has both name and subject indices and a really worthwhile bibliography.

• EPIDEMICS IN COLONIAL AMERICA. *By John Duffy. Pp. 274. Price $4.50. Baton Rouge, Louisiana State University Press, 1953.*

The American colonies were grievously affected by epidemic diseases. Both settlers and Indians were decimated. The plagues influenced history both because of the cost in lives and money and because of the influence on prevailing social patterns and religious beliefs. Duffy has selected the group of most serious and frequent diseases and has fitted them into their chronological background with interesting documentation from the period. EPIDEMICS IN COLONIAL AMERICA is illustrated, fully-indexed, and has an extensive list of bibliographic materials.

• THE PSYCHOLOGY OF MEDICAL PRACTICE. *By Marc H. Hollender, M.D. Pp. 276. Price $6.50. Philadelphia, W. B. Saunders Company, 1958.*

Hollender and three other physicians have selected a group of situations in medical practice for psychologic study and practical recommendation. The cited problems are common ones and readers will find much of interest in the opinions expressed and the examples given. J. B. Richmond, M.D., contributed the two chapters on pediatric practice, and E. M. Solomon, M.D., the chapter on obstetrics. The senior author in collaboration with L. A. Stine, M.D., presents the subject of the medical patient, with particular consideration to hospitalization, and to discussion of cerebral vascular accident, coronary disease, and diabetes mellitus. A question-and-answer form of presentation is used for most of the material, with emphasis on the significance of the therapeutic relationship. Information is included about management of the cancer patient and the surgical patient, and on the important factor of prescribed medications. THE PSYCHOLOGY OF MEDICAL PRACTICE is indexed and supplies reading references.

• PATTERNS OF MOTHERING, *A Study of Maternal Influence During Infancy. By Sylvia Brody, Ph.D. Price $7.50. New York, International Universities Press, Inc., 1956.*

Studies of the relationship between mother and offspring have been broken down into the principal aspects of infant behavior. Thirty-two babies and their mothers were under observation for six-hour periods and the results tabulated. PATTERNS OF MOTHERING includes clinical accounts, psychoanalytic assumptions, a review of previous observations, and an examination of patterns of infant feeding, growth and development. The Infancy Research Project of 1949 and 1950 supplied the impetus and the background data for this research. There is an extensive bibliography and an introduction by Rene A. Spitz, M.D.

• Religious Doctrine and Medical Practice. *By Richard Thomas Barton, M.D. Pp. 94. Price $3.75. Springfield, Charles C Thomas, 1958.*

In the treatment of patients from different cultures and religious beliefs the physician may unwittingly be brought into conflict with tenets that preclude some forms of therapy. Again, the conflict may simply be one of misunderstanding or misinterpretation of a patient's refusal or resistance. This brief and practical handbook for practitioners contains information about the religions of the world that might affect individual acceptance of medication or surgery. Dietary restrictions are well-known to most physicians but other matters that are determined by religion are less fully documented in the medical literature. The book is indexed.

• The Introvert. *By Ainslie Meares, MBBS. B. AGR. SC. DPM. Pp. 147. Price $4.50. Springfield, Charles C Thomas, 1958.*

The adaptation of the introverted individual to family and community living is an important aspect of behavior study. Meares' monograph is concerned neither with the therapy of the introvert nor with the psychopathology of clinical introversion. The subject is that of integration into society, adjustment patterns, and probable outcomes. The possibilities of mentally healthy maturation or the other extreme of chronicity or schizophrenogenesis require recognition and serious consideration. An index and a glossary are provided.

• Reversicon, *A Medical Word Finder. By J. E. Schmidt, Ph.B.S., M.D., Litt. D. Pp. 440. Price $7.50. Springfield, Charles C Thomas, 1958.*

A sensible reference plan has been incorporated into a dictionary in reverse, so that the elusive word may be looked up by its meaning. Reversicon has over 25,000 different entries, and affords both the appropriate medical term as well as related ones, because arrangement is according to the alphabetical order of the subjects. Thus, from *Hair, abnormal growth of*, to *Hairy region* there are 109 entries, and more than 109 terms, in a satisfactorily simple arrangement. There are cross references also, so that an extremely useful compilation is presented with a minimum of groping necessary. There are instances with which, perhaps, a purist might quarrel, but these are few and are more than compensated by the ease of usage and the pleasure of encountering some less-worn terms. To individuals with an active interest in the language it gives, besides, some extremely interesting reading material.

• Diseases of The Nervous System. *Described for Practitioners and Students, 9th ed. By Sir Francis Walshe, M.D., D. Sc., F.R.S. Pp. 373. Price $8. Baltimore, The Williams & Wilkins Company, 1958.*

Walshe's name requires no explanation or qualification, and after 18 years his work remains both needed and readable. In this edition there have been necessary changes. Chapters on the subject of hepatic disorder have been contributed by J. M. Walshe, M. R. C. P., and the section on general diagnostic principles has been altered. There are 60 illustrations and a brief index. References are few and incomplete, but the material is condensed and the style is clear, factual, and impressive.

• The Preservation of Youth (Fi Tadbir As-sihha). *By Moses Ben Maimon, translated from the Arabic by Hirsch L. Gordon, M.D., Ph.D., D.H.L. Pp. 92. Price $2.75. New York, Philosophical Library, Inc., 1958.*

This essay on health, by Maimonides the Spaniard, here appears for the first time in an English translation, although it was put into both Hebrew and Latin as early as the thirteenth century. The regimen was composed in 1198, in Egypt, for the Sultan Al Afdal, who was a victim of both depressive and digestive disorders. The author divided his recommendations into four parts with commendable clarity and the result is a vigorous and diverting group of instructions. The first section is on general hygiene, especially on nutrition, and in it both Hippocrates and Galen are cited, satiety and fatigue discouraged. The second part concerns care of the sick in the absence of a physician or in the care of an inadequate one (!). The author prudently recommends mild medications, and suggests a favorable effect from stories and music for diversion. The third chapter on the Sultan's particular complaints offers prescriptions, strengthening of the heart and liver, and especially discusses psychological influences. The final selection of assorted directives is mostly general in application, with a few surprising admonitions. The importance of regular habits is again remarked in this chapter. The whole is both unusual and charming.

• Rembrandt's Anatomy of Dr. Nicolaas Tulp. *By William S. Heckscher. Pp. 283. Price $15. New York, New York University Press, 1958.*

This handsome outsize volume serves both as historical examination of a famous painting and as study of the anatomical learning of the seventeenth century. It is not easy reading because of the author's somewhat convoluted style and because of the necessary and important documentation; nevertheless, it is beautifully presented and the material is detailed and colorful. Paper, print, and illustrations are fine and clear. This volume is a decorative addition to any library. There is a bibliography of over 500 items and 85 pictures are used. Heckscher, with these aids, explains the mathematical basis of anatomic artistry, rehearses the inherent symbolism, and expresses the curious atmosphere of the dissections of the time that was often both festive and macabre.

BOOKS RECEIVED

Behaviour and Physique, An Introduction to Practical and Applied Somatometry. By R. W. Parnell, D.M., M.R.C.P. Pp. 134. Price $7. Baltimore, The Williams & Wilkins Company (London, Edward Arnold Publishers Ltd.), 1958.

The Education of the Individual. By Alfred Adler. Pp. 143. Price $3.50. New York, Philosophical Library, Inc., 1958.

Existentialism and Education. By George F. Kneller. Pp. 170. Price $3.75. New York, Philosophical Library, Inc., 1958.

Human Potentialities. By Gardner Murphy. Pp. 340. Price $6. New York, Basic Books, Inc., 1958.

Young Children in Hospitals. By James Robertson. Pp. 136. Price $3. New York, Basic Books, Inc., 1958.

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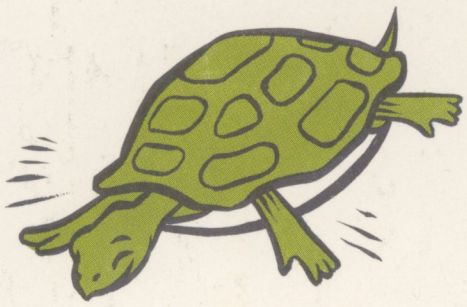

"Everything that enlarges the sphere of human powers, that shows man he can do what he thought he could not do, is valuable."

—Samuel Johnson